movementplus

Advanced Institute of Physical Therapy

REACTIVATED/UPDATED PATIENT INFORMATION FORM

**Please inform front desk of any changes to contact or insurance information.

Date: _____

Name: _____ **Date of Birth:** _____

Select one:

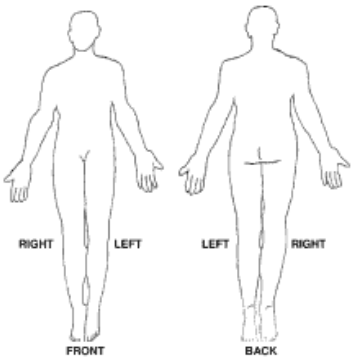
- **New Condition** – *I am currently under care with a new condition.*
- **Returning Patient** – *I am returning for care after a period of inactivity.*

Current symptoms: _____

1. When did you first notice your current symptoms? _____
2. How often do your symptoms occur? ___ Constantly ___ Intermittently
3. Rate your pain on the scale below.

4. Where does it hurt?

Mark the area(s) on the illustration below. "X" for current pain.



5. Quality of symptoms: *(What does it feel like? Mark "X" all that apply)*
   ___ *Numbness* ___ *Tingling* ___ *Dull* ___ *Aching* ___ *Shooting*
   ___ *Stiffness* ___ *Cramps* ___ *Sharp* ___ *Burning* ___ *Stabbing*
   Other: _____
6. Does the pain radiate to other areas of your body? __ Yes ___ No
7. What makes the pain better or worse? (Time of day, movement, activities, etc.)
   _____
   _____
8. Prior interventions: *(What have you done to relieve the symptoms? Mark "X" all that apply)*
   ___ *Prescription medications* ___ *Over-the-counter drugs* ___ *Acupuncture* ___ *Surgery*
   ___ *Physical Therapy* ___ *Massage* ___ *Heat* ___ *Ice*
9. Illness, operations, injuries, changes in health since last evaluation? ___ Yes ___ No
   If yes explain: _____

For office use:

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SPC 410 Aiea, HI 96701

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888 Honolulu, HI 96814

Waipahu
94-216 Farrington Hwy.,
Ste A-102 Waipahu, HI 96797

10. Activities of Daily Living *(How does this condition currently interfere your life and ability to function?*

	No Effect	*Mild Effect*	*Moderate Effect*	*Severe Effect*		*No Effect*	*Mild Effect*	*Moderate Effect*	*Severe Effect*
Sitting	☐	☐	☐	☐	Getting in/out of car	☐	☐	☐	☐
Standing	☐	☐	☐	☐	Reaching overhead	☐	☐	☐	☐
Walking	☐	☐	☐	☐	Caring for family	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐	Household chores	☐	☐	☐	☐
Exercising	☐	☐	☐	☐	Lifting objects	☐	☐	☐	☐
Bending over	☐	☐	☐	☐	Dressing myself	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	Looking over shoulder	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐	Showering or bathing	☐	☐	☐	☐
					Using a computer	☐	☐	☐	☐

11. In addition to the main reason for your visit today, what additional health goals do you have?

_____

Acknowledgements

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement, and initial your agreement.

Initials

_____ I instruct the provider to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health.

_____ I acknowledge and may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realized that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I received.

_____ I acknowledge that I have informed the front desk of any and all insurance(s) I have. I have not withheld any additional insurance information. I understand that I will be fully financially responsible for giving false information in regards to my insurance.

_____ I acknowledge that should any of my insurance information change (i.e., plan type, subscriber, etc.) I will immediately inform the front desk.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

_____ **I acknowledge that a 24-hour cancellation notice is required. Without proper notification a missed appointment may result in a $30 cancellation fee.**

If the patient is a minor child, print child's full name: _____

Signature: _____ Date: _____